EL PASO INDEPENDENT SCHOOL DISTRICT

Health Services Department

Seizure Action Plan

THE STUDENT IDENTIFIED BELOW IS TREATED FOR A SEIZURE DISORDER & THE INFORMATION PROVIDED BELOW IS TO ASSIST YOU IF A SEZIURE OCCURS DURING SCHOOL HOURS.

Student's Name: _____ID#:_____ DOB: _____
School: _____Year:20_____ -20_____
Significant Medical History/ Diagnosis: _____
Allergies: _____
What triggers your child to have a seizure? _____
_____
What warning/behavioral changes occur before a seizure? _____
_____

Types of Seizures/Seizure Information

Seizure Type	Average Length	Frequency	Description

Treatment during School Hours

Medication	Dose/Amount	Time/Frequency	Route	Special Instructions

Emergency Rescue Medications

Medication	Dose/Amount	Time/Frequency	Route	Special Instructions

Does Student Have a VNS (Vagus Nerve Stimulator) _____YES_____NO
IF YES PLEASE DESCRIBE MAGNET USE: _____
_____

CALL 911: If seizure last longer than 5 minutes. Student has repeated seizures without regaining consciousness. Student is injured or has diabetes. Student has a first-time seizure. Student has breathing difficulties.

Special Precautions/Restrictions Regarding School Activities: (Ex: Bus Transportation, Field Trips, and Physical Education_____
_____

I, the undersigned, as the physician for the above-named student, approve the following health care procedure(s) to be administered to this student during school hours by trained staff. I agree that this authorization for the procedure(s) will stand for the current school year or until there is a change or cancellation of the procedure(s) during the current school year.

_____ _____ _____
Parent's Signature **Phone Number** **Date**

_____ _____ _____
Practitioner's Signature **Office Phone Number** **Date**

_____
Practitioner's Name

REV 6/23